CHAPTER 12
ADDENDUM D

CMS FORM 485 - HOME HEALTH CERTIFICATION AND PLAN OF CARE DATA ELEMENTS

Standardized data collection facilitates accurate coverage decisions, helps to ensure correct payment for covered services and promotes compliance with federal laws and regulations. The CMS Form 485 (the Home Health Certification and Plan of Care) meets regulatory and national survey requirements for the physician's POC, certification and recertification. CMS Form 485 provides a convenient way to submit a signed and dated POC, however, HHAs may submit any document that is signed and dated by the physician that contains all of the required components of the POC as described below. The signed POC is maintained in the beneficiary's medical record at the HHA with a copy of the signed POC available upon request when needed for MR. HHAs are required to obtain a signed POC as soon as practical after the start of care and prior to submitting the claim.

The following items are contained on the CMS Form 485:

No.	Data Element	Description:
1	Patient's HICN	The HICN (numeric plus alpha indicator(s)) as shown on the patient's health insurance card, certificate award, utilization notice, temporary eligibility notice, or as reported by the SSO.
2	Start of Care (SOC) Date	The HHA enters the month, day, year on which covered home health services began, i.e., MMDDYYYY (03012000). The SOC date is the first Medicare billable visit. This date remains the same on subsequent plans of care until the patient is discharged. Home health may be suspended and later resumed under the same SOC date in accordance with the HHA's internal procedures.
3	Certification Period	a. For Dates of Service before the effective date of the home health prospective payment system (HHPPS) (October 1, 2000): b. The HHA enters the month, day, year, e.g., MMDDYYYY that identifies the period covered by the physician's POC. The "From" date for the initial certification must match the SOC date. The "To" date can be up to, but never exceed 2 calendar months and, mathematically, never exceed 62 days. The "To" date is repeated on a subsequent re-certification as the next sequential "From" date. Services delivered on the "To" date are covered in the next certification period.

EXAMPLE: Initial certification "From" date 03012000; Initial certification "To" date 05012000; Re-certification "From" date 05012000; Re-certification "To" date 07012000.

c. For Dates of Service on or after the effective date of HH PPS (October 1, 2000): The HHA enters the month, day, year, e.g., MMDDYYYY that identifies the period covered by the physician's POC. The "From" date for the initial certification must match the SOC date. The "To" date is up to and including the last day of the episode which is not the first day of the subsequent episode. The "To" date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days.

EXAMPLE: Initial certification "From" date 10012000; Initial certification "To" date 11292000; Re-certification "From" date 11302000; Re-certification "To" date 01282001.

NOTE: Services delivered on 11292000 are covered in the initial certification episode.

4	Medical Record No.	This is the patient's medical record number that is assigned by the HHA and is an optional item. If not applicable, the agency enters "N/A."
5	Provider No.	This is the 6 digit number issued by Medicare to the HHA. It contains 2 digits, a hyphen, and 4 digits (e.g., 00-7000).
6	Patient's Name and Address	The HHA enters the patient's last name, first name, and middle initial as shown on the health insurance card and the street address, city, State, and ZIP code.
7	Provider's Name, Address and Telephone No	The HHA enters its name and/or branch office (if appropriate), street address (or other legal address), city, State and ZIP code and telephone number.
8	Date of Birth	The patient's date of birth (month, day, year) in numbers, i.e., MMDDYYYY (04031920) is entered.
9	Sex	The patient's sex is checked in the appropriate box.
10	Medications: Dose, Frequency, Route	The physician's orders for all medications including the dosage, frequency and route of administration for each drug must be listed.
11	Principal Diagnosis, ICD-9-CM Code and Date of Onset, Exacerbation	The principal diagnosis is the diagnosis most related to the current POC. The diagnosis may or may not be related to the patient's most recent hospital stay, but must relate to the services rendered by the HHA. If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be entered. The ICD-9-CM guidelines dictate that certain specific principle diagnoses are only to be used when a specific secondary diagnosis is present.

Using the ICD-9-CM coding guidelines, the HHA enters the appropriate ICD-9-CM code for the principal diagnosis in the space provided. The code is the full ICD-9-CM diagnosis code including all digits. Prior to the effective date of HHPPS, V codes are acceptable as principle and secondary diagnoses. In many instances, the V code more accurately reflects the care provided. However, the V code should not be used when the acute diagnosis code is more specific to the exact nature of the patient's condition. After the implementation of HHPPS, the principle diagnosis must match on the physician certified POC, the Outcome and Assessment Information Set (OASIS) and the Uniform Billing Form 92 (UB-92). In addition, V codes are NOT acceptable as principle or first secondary diagnoses but could be recorded in item 21 entitled Orders for Discipline and Treatments. The ICD-9-CM coding guidelines should be followed in assigning an appropriate V code.

EXAMPLES: (Prior to the effective date of HHPPS) 1) Patient is surgically treated for a subtrochanteric fracture (code 820.22). Admission to home care is for rehabilitation services (V57.1). The HHA uses 820.22 as the principle diagnosis since V57.1 does not specify the type or location of the fracture.

2) Patient is surgically treated for a malignant neoplasm of the descending colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). The HHA uses V55.3 as the primary diagnosis since it is more specific to the nature of the proposed services.

EXAMPLE: (After the effective date of HHPPS) 1) Patient is surgically treated for a subtrochanteric fracture (code 820.22). Admission to home care is for rehabilitation services (V57.1). The HHA uses 820.22 as the primary diagnosis and may enter V57.1 as a second secondary diagnosis or in field 21.

2) Patient is surgically treated for a malignant neoplasm of the descending colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). Even though V55.3 is more specific to the nature of the proposed service, the HHA must use code 153.2 as the principle diagnosis and may use V55.3 as a second secondary diagnosis or in field 21.

The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than those on the established POC.

The medical diagnostic term is listed next to the ICD-9-CM code. The date reflects either the date of onset, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact day is not known, the HHA uses 00 for the day.

12	Surgical Procedure, Date, ICD-9-CM Code	The surgical procedure relevant to the care being rendered is entered. For example, if the diagnosis in Item 11 is "Fractured Left Hip," the ICD-9-CM Code, the surgical procedure and date are noted (e.g., 81.52, Partial Hip Replacement, 060998).

If a surgical procedure was not performed or is not relevant to the POC, N/A is inserted. The addendum is used for additional relevant surgical procedures. At a minimum, the month and year must be present for date of surgery.

13	Other Pertinent Diagnoses: Dates of Onset/ Exacerbation, ICD-9-CM Code	Enter all pertinent diagnoses, both narrative and ICD-9-CM codes, relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the POC was established, or which developed subsequently, or that affect the treatment of care. Exclude diagnoses that relate to an earlier episode which have no bearing on this POC.

These diagnoses can be changed to reflect changes in the patient's condition however, they must match the diagnoses listed on the OASIS and the UB-92 and conform with the ICD-9-CM coding guidelines.

In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. However, there may be exceptions to this rule, dictated by ICD-9-CM coding sequencing requirements. For example, if a principle diagnosis exists which dictates the utilization of a specific secondary diagnosis, then the agency should list this secondary diagnosis first in the list of "other pertinent diagnoses". If there are more than four pertinent secondary diagnoses, use an addendum to list them. Enter N/A if there are no pertinent diagnoses.

The date reflects either the date of onset if it is a new diagnosis or the date of the most recent exacerbation of a previous diagnosis. Note that the date of onset or exacerbation must be as close to the actual date as possible. If the date is unknown, note the year and place 00s in the month or day if not known.

14	DME and Supplies	All non-routine supplies must be specifically ordered by the physician or the physician's order for services must require use of the specific supplies. The HHA enters in this item non-routine supplies that are not specifically required by the order for services. For example, an order for foley insertion requires specific supplies, i.e., foley, catheter tray. Therefore, these supplies are not required to be listed. Conversely, an order for wound care may require use of non-routine supplies which would vary by patient. Therefore, the non-routine supplies would be listed.

If the HHA lists a commonly used commercially packaged kit, it is not required to list the individual components. However, if there is a question of cost or content, the contractor can request a breakdown of kit components.

Contractors should reference Chapter 12, Section 2 for a definition of non-routine supplies.

The HHA also lists DME ordered by the physician that will be billed to Medicare. The HHA enters N/A if no supplies or DME are billed.

15	Safety Measures	The physician's instructions for safety measures are listed.
16	Nutritional Requirements	The HHA enters the physician's orders for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Fluid needs or restrictions are recorded. Total parenteral nutrition (TPN) can be listed under this item or under medications if more space is needed.

17	Allergies	Medications to which the patient is allergic are listed. In addition, other allergies the patient experiences (e.g., foods, adhesive tape, iodine) are included.
18A	Functional Limitations	All items that describe the patient's current limitations as assessed by the physician and the agency are indicated.
18B	Activities Permitted	The activity(ies) that the physician allows and/or for which physician orders are present are indicated.

If "Other" is checked under Item 18A or 18B, a narrative explanation is required.

19	Mental Status	The block(s) most appropriate to describe the patient's mental status is checked. If "Other" is checked, the patient's condition is specified here.
20	Prognosis	A check is placed in the box which specifies the most appropriate prognosis for the patient; poor, guarded, fair, good or excellent.

NOTE: The number or letter adjacent to the blocks in Items 18 though 20 correspond to the codes for EMC transmission only.

21	Orders for Discipline and Treatments (Specify Amount, Frequency, Duration)	The physician must specify the frequency and the expected duration of the visits for each discipline. The duties/ treatments to be performed by each discipline must be stated. A discipline may be one or more of the following: SN, PT, ST, OT, MSS, or AIDE.

Orders must include all disciplines and treatments, even if they are not billable to TRICARE. In general, the narrative explanation for applicable treatment codes is acceptable as the order when that narrative is sufficiently descriptive of the services to be furnished. However, additional explanation is required in this item to describe specific services, i.e., A1, A4, A5, A6, A7, A22, A23, A28, A29, A32, B15, C9, D11, E4, E6, and F15. Additional explanation is also required where the physician has ordered specific treatment, medications, or supplies. When aide services are needed to furnish personal care, an order for "personal care" is sufficient. See example of orders below.

Frequency denotes the number of visits per discipline to be rendered, stated in days, weeks, or months. Duration identifies the length of time the services are to be rendered and may be expressed in days, weeks, or months.

Example of Physician's Orders: Certification period is from 03012000 - 05012000:

OT - Eval., Activities of Daily Living (ADL) training, fine motor coordination 3x/wk x 6wks
ST - Eval., speech articulation disorder treatment 3x/wk x 4wks
SN - Skilled observation and assessment of C/P and neuro status instruct meds and diet/hydration 3x/wk x 2wks
MSS - Assessment of emotional and social factors 1x/mo x 2mos
AIDE - Assist with personal care, catheter care 3x/wk x 9wks

Specific services rendered by physical, speech, and occupational therapists may involve different modalities. The "AMOUNT" is necessary when a discipline is providing a specific modality for therapy. Modalities usually mentioned are heat, sound, cold, and electronic stimulation.

EXAMPLE: PT - To apply hot packs to the C5-C6 x 10 minutes 3x/wk x 2wks.

PRN visits may be ordered on a POC only where they are qualified in a manner that is specific to the patient's potential needs. Both the nature of the services and the number of PRN visits to be permitted for each type of service is specified in the POC. Open-ended, unqualified PRN visits do not constitute physician orders for patient care since neither the nature, nor the frequency of the service is specified.

EXAMPLE: Skilled nursing visits 1xm x 2m for Foley change and PRN x 2 for emergency Foley irrigation and/or changes.

22	Goals and Rehabilitation Potential/Discharge Plans	This reflects the physician's description of the achievable goals and the patient's ability to meet them as well as plans for care after discharge.

Examples of realistic goals:

- Independence in transfers and ambulating with walker;
- Healing of leg ulcer(s);
- Maintain patency of Foley catheter. Decrease risk of urinary infection;
- Achieve optimal level of cardiovascular status. Medication and diet compliance; and
- Ability to demonstrate correct insulin preparation/administration.

Rehabilitation potential addresses the patient's ability to attain the goals and an estimate of the time needed to achieve them. This information should be pertinent to the nature of the patient's condition and ability to respond. The words "Fair" or "Poor" alone, are not acceptable. Instead, descriptors must be added:

EXAMPLE: Rehabilitation potential is good for partial return to previous level of care, but patient will probably not be able to perform ADL independently.

Where daily care has been ordered, the agency must be specific as to the goals and when the need for daily care is expected to end. Discharge plans include a statement of where or how the patient will be cared for once home health services are no longer provided.

23	Nurse's Signature and Date of Verbal SOC	This verifies for surveyors, CMS's representatives, and the RHHI that a registered nurse, qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker), or any health professional responsible for furnishing or supervising the patient's care, spoke to the attending physician and received verbal authorization to visit the patient. This date may precede the SOC date in Item 2 and may precede the "From" date in Item 3.

This field may be used to document receipt of verbal orders when services are furnished prior to the physician's written orders on SOC or re-certification. If this field is used, the order must be written on CMS Form 485 and signed and dated with the date of receipt by the nurse, therapist, social worker, or qualified health professional to begin or modify care or continue care at re-certification.

This item is signed by the nurse, qualified therapist, social worker, or health professional responsible for the completion of CMS Form 485, or by non-clerical personnel authorized to do so by applicable State and Federal laws and regulation, as well as by the HHA's internal policies. The HHA enters N/A if the physician has signed and dated CMS Form 485 on or before the SOC or re-certification date, or has submitted a written order to start, modify, or continue care on a document other than CMS Form 485.

24	Physician's Name and Address	The agency prints the physician's name and address. The attending physician is the physician who established the POC and who certifies and re-certifies the medical necessity of the home health visits and/or services. Supplemental physicians involved in a patient's care are mentioned on the addendum only. The physician must be qualified to sign the certification and POC in accordance with 42 CFR 424 Subpart B. Physicians who have significant ownership interest in, or a significant financial or contractual relationship with an HHA may not establish or review a plan of treatment or certify or re-certify the need for home health services.
25	Date HHA Received Signed POC	The date the agency received the signed POC from the attending/referring physician is entered. It is required only if the physician does not date Item 27. The agency enters N/A if Item 27 date is completed.
26	Physician Certification	This statement serves to verify that the physician has reviewed the POC and certifies to the need for the services.

27	Attending Physician's Signature and Date	The attending physician signs and dates the POC/ certification prior to the claim being submitted for payment; rubber signature stamps are not acceptable. The form may be signed by another physician who is authorized by the attending physician to care for his/her patients in his/her absence. While the regulations specify that documents must be signed, they do not prohibit the transmission of the POC or oral order via facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature. HHAs which maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records upon request from the intermediary, state surveyor, or other authorized personnel, or in the event of a system breakdown.

The agency should not predate the orders for the physician, nor write the date in this field. If the physician left it blank, the agency should enter the date it received the signed POC under Item 25. An unsigned copy is submitted to you with the signed copy retained in the agency's files.

28	Penalty Statement	This statement specifies the penalties imposed for misrepresentation, falsification, or concealment of essential information on the CMS Form 485.

When additional space is needed to complete CMS Form 485 fields, HHAs use an addendum signed by the physician.